

Community pharmacists have some good news to celebrate, reports

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Let's praise LPS

It's time to break out the champagne. For years now, everything that could go wrong has gone wrong. No contractor in the country needs reminding about the recent financial disasters, from extra spending on clinical governance to rising locum costs.

But despite the doom and gloom, independents and retail chains now have a genuine reason to pop their corks.

Soon the stability will return to the business of pharmacy, with guaranteed incomes, stable resale values and perhaps higher revenues for the chosen few.

Later this year, pharmacies that have chosen to do so will be able to submit three year plans to the Department of Health outlining what they would like to do, and how much it will cost.

For contractors tired of waiting

for their national representatives to do something positive for their businesses, the frustration may soon be over.

Pharmacies will soon be able to elect to provide dispensing, and other, innovative, services to local patients under the Government's new Local Pharmaceutical Services (LPS) scheme.

Under this voluntary initiative, lucky contractors will be able to directly negotiate their own contracts, set their own targets and agree financial terms that suit themselves and the NHS.

The LPS scheme was made law by clauses 29 to 41 of the Health and Social Care Bill enacted in 2001.

Since this legislation was passed, the Department of Health has been working on proposals for the scheme and recently asked for

comments before guidance is published in spring 2002.

Although the scheme has not been officially launched yet, enough information has appeared in the public domain and the pharmacy press to predict what the regulations governing the LPS scheme may be like.

LPS pilots are likely to provide an alternative to the existing national contract that will:

- develop innovative ways of contracting for core pharmacy services like dispensing
- explore ways of providing a wider range of services within community pharmacy
- offer community pharmacists and pharmacy owners an opportunity to work within a contract they help design
- provide better quality services and care to patients.

For contractors running a business, the scheme offers new opportunities and new constraints.

For example, LPS providers will be free to provide innovative services such as diagnostic testing, or health education.

However, they will have to continue dispensing, stay within budget, supply pilot data and facilitate monitoring by a national evaluator and local PCT.

Although there may be much to celebrate, as yet unrevealed aspects of the scheme could be equally important.

● National and local pharmacy bodies may have no input into day-to-day issues such as budget-setting and appropriate fees, as the scheme operates solely (and privately) between the NHS and LPS provider sites.

● Local Pharmaceutical Committees, Primary Care Trusts and dispensing doctors will not be able to directly run LPS pilots (unless they form bodies corporate) and they have no special rights of information or veto.

● As they may fund dispensing, LPS pilots could be designed to protect traditional community pharmacy, making innovative services a necessary sideline for many LPS providers.

These factors could create an opportunity for contractors to move away from a nationally-negotiated remuneration system to local arrangements.

As an example, a pharmacy with an NHS turnover of £250,000 could (in theory) bid for £270,000 to provide its existing dispensing service plus a few flashy add-ons, and have this money paid in monthly instalments for its whole time in the scheme.

If it negotiated its contract correctly, this pharmacy could become immune to reductions in the dispensing fee, as LPS makes its revenue a local issue.

As it involves locally-negotiated, three year contracts, HAs and PCTs could use the LPS initiative to re-organise local pharmacy outlets, for example, by opening new premises.

Indeed, subject to Government approval, an important feature of LPS may be the ability of HAs and PCTs to jointly create "designated" neighbourhoods, premises and descriptions of premises.

At present, NHS pharmacy is mainly funded from the global sum, which can only be secured locally if there is a dispensing pharmacist, and a doctor nearby who prescribes.

In deprived parts of the UK

"Once budgets are allocated, risk management will become a critical issue"

that lack a pharmacy, a general practitioner, or both, patients often suffer because the local PCT is unable to secure pharmacy monies unless dispensing takes place.

Under LPS, however, it will be theoretically possible for PCTs to bid for pharmacy funds without a pharmacy being open.

Therefore, PCTs may use the LPS scheme to promote access (or extend services) in areas previously not viable (or desirable) to contractors paid by the dispensing fee.

To date, much emphasis has been placed on the possible design and organisation of LPS pilots.

However, once the scheme is launched, the most important factor for participating providers will be money.

Indeed, LPS is not primarily about pharmacy services, but about moving from the national global sum to local pharmacy budgets distributed by PCTs.

In relation to money, the first issue facing LPS pilots will be deciding how much to charge for their services.

Although alternative funding methods could be used, a satisfactory short-term approach could be budgets based upon the total amount currently received from dispensing, plus an uplift for IT and pilot development of about 10-15 per cent.

For new providers, on the other hand, the cost of proposed services could be calculated and an appropriate budget allocation submitted to the DoH.

Once budgets are allocated, risk management will become a critical issue to cash-limited pilots.

If they opt for a fixed, annual budget, LPS providers will have to manage the risk of their expenditure rising above their revenues, as their pilots attract unforeseen demand.

The pilots' successes will consequently depend on their ability to secure appropriate budgets, control costs and ration the services they provide.

However, providers will not be exempt from their duties and ethics as pharmacists, and rejecting dispensable scripts will not be an acceptable way of managing their financial affairs.

Indeed, it is likely that most HAs and PCTs will introduce

strict contracts and pilot monitoring that discourage reductions in dispensing volumes as a way of handling their costs.

Whether particular pilots are successful or not will depend, to a large degree, upon the contracts they sign.

Counter-intuitively, however, over-long or complex contracts may not contribute to pilot success, as longer or more detailed agreements don't mean that a pilot will work well in practice.

Indeed, evidence from contracting in other parts of the NHS suggests that good relationships between purchasers and providers are more important than the finer details of contracts.

Therefore, pilots should attempt to agree contracts that are explicit about the services they plan to offer and the standards they will meet, but they should only view this as a starting block from which to launch into LPS success.

For providers who find their agreements unacceptable in the longer-term, the LPS scheme offers some opportunities for contract renegotiations, as well as the right for providers to return to the standard regulations for community pharmacies.

In a world in which the national dispensing fee has been cut, some pharmacists may decide to take greater control over their own destinies by joining the LPS scheme.

However, potential providers must realise that their LPS proposals must first be accepted by their local HA and, then, the DoH.

In the first instance, interesting or safe bids may receive approval.

However, before final contracts are negotiated, wise providers will strive to learn more about alternative approaches to contract design, budget-setting and controlling pilot costs.

Providers who concentrate solely on deciding what services to provide and not on management issues may find that their plans never achieve success.

If the DoH and Parliament allow the LPS scheme to be designed in the way described here, an understanding of management (rather than an in-depth knowledge of medicines) may be what marks out successful pharmacies within the NHS.

Key features

1. The LPS scheme is voluntary, no pharmacy has the right to join, and the existing arrangements for non-participating pharmacies still remain in place.

2. Interested parties must register their outline proposals with their local HAs/PCTs, which must select proposals for submission to the DoH.

3. Outline proposals may be submitted by anybody, including existing pharmacy contractors, other individuals, bodies corporate, NHS Trusts, or may be devised by HAs/PCTs themselves.

4. Health authorities will initially lead in putting forward and managing pilots, and this role will eventually pass to PCTs.

5. PCTs will not themselves be providers of LPS, and no formal role has yet been given to Local Pharmaceutical Committees.

6. Pilots must include dispensing services (whether to general or particular groups of patients) and may not include dispensing by doctors, unless they form new organisations for providing LPS services.

7. Pilots can include arrangements for the provision of training and education, including for those involved (or who may later be involved) in the scheme.

8. Pilots may not be combined with PMS or PDS in the same contract although a separate LPS contract may be held alongside either.

9. Although some models will be more appropriate than others, there is no favoured type of provider arrangement for pilots.

10. Subject to government regulations, HAs/PCTs will have the power to designate neighbourhoods, premises and description of premises for the purposes of LPS.

Dr Darrin Baines is the director of medM Ltd. Details of the company's conferences, workshops and advice services on the LPS scheme are available at www.medm.co.uk